

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

CERTIFICATE OF DEATH

06770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY QUEEN ANNES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 4 1/2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		d. STREET ADDRESS 17 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERLY SHORE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle E	Last BASH	4. DATE OF DEATH	Month JUNE	Day 17	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC 30 1876	9. AGE (in years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME EDWARD H BASH		14. MOTHER'S MAIDEN NAME MARY KER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. SPANISH-AMER NONE		17. INFORMANT HOSPITAL RECORDS		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS. 422.2		DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) CEREBRAL HEMORRHAGE		3 WEEKS			
		(c) CEREBRAL ARTERIOSCLEROSIS.		OVER 4 1/2 YRS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CHRONIC BRAIN SYNDROME						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ESS HOSPITAL	20f. (City or town) Bethelvale	(County) Maryland	(State) Maryland	
21. I certify that I attended the deceased from APR 25, 1957 , to JUNE 17, 1958 , that I last saw the deceased alive on JUNE 16, 1958 , and that death occurred at 120 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry J. Crawford				ADDRESS (Street, city or town, state) JUNE 17, 1958		DATE SIGNED	
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 18, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield	22d. LOCATION (City, town, or county) Bethelvale	(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Butler, Jr., of Belvoir, Chesterfield, VA.		ADDRESS 1101 Belvoir Rd., Chesterfield, VA.	24a. REGD. BY REGISTRAR 1101 Belvoir Rd., Chesterfield, VA.	DATE June 18, 1958			24b. REGISTRAR'S SIGNATURE John E. Brown

WISCONSIN STATE DEPARTMENT OF LABOR - DIVISION OF
CERTIFICATES OF DEATH

290043

DEATHS

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

20100

20101

20102

20103

20104

20105

20106

20107

20108

20109

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

20117

20118

20119

20110

20111

20112

20113

20114

20115

20116

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06771

Reg. Dist. No. **06771**

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.		PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. COUNTY		Dorchester MARYLAND		a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cambridge		25 years		13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Cambridge-Maryland Hospital		1 23 High Street			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH Month Day Year
Female		Alverda	Dunbar	Bayly	June 13, 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 18, 1874	84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				Cambridge	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Alexander Hamilton Bayly		Margaret Craig		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		None		Ann Lloyd Slagle, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> INTERVAL BETWEEN ONSET AND DEATH ? MEDIAL CAUSE (b) <u>Generalized arteriosclerosis</u> ? DUE TO					
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause first. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Fracture neck femur 904.0					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in her home, unable to arise.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3PM p. m. May 31, 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Cambridge, Dor. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/30/58	
EXAMINER'S NAME (Type) Dr. John Mace Jr.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 14, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Christ Churchyard	
22d. LOCATION (City, town, or county) Cambridge, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard P. DeWitt</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '58 24b. REGISTRAR'S SIGNATURE <i>Alfred Heath</i>	

Two for one certificate Film G231 - 7/11/58-mb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06772

FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Life		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 127 Washington Street		e. STREET ADDRESS 127 Washington Street	
3. NAME OF DECEASED (Type or print) Minnie Bishop		First Minnie	Middle Bishop
4. DATE OF DEATH June 26, 1958		Last Bowley	Month June Doy 26 Year 1958
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 11, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
13. FATHER'S NAME William Bishop		14. MOTHER'S MAIDEN NAME Mary Bishop Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) NO		16. SOCIAL SECURITY NO. 220-10-6166	17. INFORMANT Thomas Bowley, Cambridge, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 782.4 DUE TO Myocardial failure Condition, if any, which gave rise to immediate cause (b) Condition, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/27/58
EXAMINER'S NAME (Type) Dr. John Mace Jr.	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland (State)
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22f. DATE THEREOF 6/30/1958		24a. REC'D BY REGISTRAR DATE JUL 8 '58
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert McElroy</i>	24b. REGISTRAR'S SIGNATURE		

17 APR 1968 - STATION TO TELFORD - 1000 METRES
HTAB NO 284511023 1000 METRES TAD 1051

2062 201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6801 CERTIFICATE OF DEATH

06773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eldorado				d. STREET ADDRESS Eldorado				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Minnie		Middle Victoria		Last Boyce		4. DATE OF DEATH June 13	Month Day Year 58 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Marine				14. MOTHER'S MAIDEN NAME Margaret Fisher				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT L. Curtis Boyce, Rhodesdale, Maryland, RFD		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arterosclerosis 1 week (c) General arterosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 126 Bloomingdale	(County) Federalsburg	(State) MD
21. I certify that I attended the deceased from 6 June, 1958 , to 13 June, 1958 , that I last saw the deceased alive on 6 June, 1958 , and that death occurred at 11:40PM from the causes and on the date stated above.								
ACTUAL SIGNATURE H. R. Trapnell, M.D. ADDRESS (Street, city or town, state) 126 Bloomingdale Federalsburg MD DATE SIGNED 6-12-58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Eldorado Cemetery		22d. LOCATION (City, town, or county) Eldorado, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				ADDRESS		24a. REG'D BY REGISTRAR JUN 20 1958	24b. REGISTRAR'S SIGNATURE Alt. Leach	

BY JOURNALIST—ALLEGED TO HAVE BEEN STATE CHIEF OF

NTABO TO STAVRILIS 10/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6802 CERTIFICATE OF DEATH 06774

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 2		c. LENGTH OF STAY IN lb 3 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge RFD # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Byron	Middle A.	Last Cameron	
4. DATE OF DEATH	Month June	Day 28,	Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/66	
9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months 	11. IF UNDER 24 HRS. Days 	12. IF UNDER 24 HRS. Hours 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Game Warden	10b. KIND OF BUSINESS OR INDUSTRY Game	11. BIRTHPLACE (State or foreign country) Ray Brook, N.Y.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Duncan Cameron	14. MOTHER'S MAIDEN NAME Lydia Ames	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Donald D. Cameron	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last. (b) DUE TO Coronary occlusion DUE TO Coronary Heart Disease	INTERVAL BETWEEN ONSET AND DEATH sudden .8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 613 1/24	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/13/54 , 19_____, to 6/28 , 19_____, that I last saw the deceased alive on 6/9/58 , 19_____, and that death occurred at 900 M, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D. ADDRESS (Street, city or town, state) 136 Race St. DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/58	22c. NAME OF CEMETERY OR CREMATORIUM NorthElba Cemetery	22d. LOCATION (City, town, or county) (State) Lake Placid, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service	ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE JUL 2 '58	24b. REGISTRAR'S SIGNATURE Albert LeCompte	

제 3장 대체로는 차이가 없지만, 그 차이는 차이가 있는 것이다.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6803

CERTIFICATE OF DEATH

06775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY CAROLINE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 9 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ALEXANDER	Middle LINCOLN	Last CHERRY	4. DATE OF DEATH JUNE 9 1958	Month JUNE	Day 9	Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20 1871	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE CO.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME THOMAS CHERRY		14. MOTHER'S MAIDEN NAME JANET GILCHRIST		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL RECORDS				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		LOBAR PNEUMONIA				INTERVAL BETWEEN ONSET AND DEATH 54 HOURS		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		MITRAL STENOSIS				UNKNOWN		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME WITH SENILE BRAIN DISEASE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MILFORD, DELAWARE	(County) MILFORD, DELAWARE	(State) DE	
21. I certify that I attended the deceased from APRIL 20, 1957 , to JUNE 9, 1958 , that I last saw the deceased alive on JUNE 8, 1958 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ADDRESS NAME (Signature) Harry J. Crawford						DATE SIGNED JUNE 9, 1958		
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM ODD FELLOWS CEMETERY		22d. LOCATION (City, town, or county) MILFORD, DELAWARE		(State) DE
23. FUNERAL DIRECTOR'S SIGNATURE J. Hampton Lee Federalsbury md		ADDRESS J. Hampton Lee Federalsbury md		24a. REC'D BY REGISTRAR DATE JUN 12 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 (4) the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 6 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ella	Middle Virginia	Last Coleman	4. DATE OF DEATH June 24	Month Year Day Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-65	9. AGE (In years last birthday) 92 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Satterfield		14. MOTHER'S MAIDEN NAME Ella Eisenbrey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Records E.S.S.H. Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 904.7 Terminal pneumonia INTERVAL BETWEEN ONSET AND DEATH 4 days					
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Neck 1. femur 2 Mo.					
DUE TO { (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Cause of Death Pushed by another inmate and fell to floor.					
20c. TIME OF INJURY Month, Day, Year Hour 6 AM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John Mae Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6/24/58
EXAMINER'S NAME (Type) John Mae Jr.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-26-58	22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel	22d. LOCATION (City, town, or county) Rock Hall Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ed Lane</i>	ADDRESS Church Hill	24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE <i>Debsch</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V - A - M

B - E - V - D

C - U - R - I

W

861

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06777

6805

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harrison Ferry		d. STREET ADDRESS Harrison Ferry		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Leila		First Leila	Middle Mae	Last Conway	4. DATE OF DEATH Month June	Day 1	Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Sept. 20, 1872	9. AGE (in years last birthday) 85 yr.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Robert H. Conway				14. MOTHER'S MAIDEN NAME Jennie Medford				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Tel. no. or envelope) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Olin P. Conway, Hurlock, Maryland, R.F.D.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH ? 2 weeks ? 20 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Cystitis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 30 , 1958, to June 1 , 1958, that I last saw the deceased alive on May 30 , 1958, and that death occurred at 10:50 AM , from the causes and on the date stated above ACTUAL SIGNATURE Jay B. Plummer M.D. ADDRESS (Street, city or town, state) Preston, Md. DATE SIGNED 6-5-58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Saint Paul Cemetery		22d. LOCATION (City, town, or county) Near Hurlock, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '58		24b. REGISTRAR'S SIGNATURE Quinn		



06778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

6779

Reg. Dist. No

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge, Md.		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
		Life				212 Pine St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		212 Pine St.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year
Marguerite		S.	Cornish		June 33		1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years from birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.
Female		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 25, 1924	33 yrs.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Food packing		Maryland		USA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Richard Sharp		Mary Roberts					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no., or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
		220-01-2833		Edward Cornish		212 Pine St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/9/58	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/58	22c. NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		22d. LOCATION (City, town, or county) Cordtown, Dor.	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert St Clair		ADDRESS Cambridge, d.			24a. REC'D BY REGISTRAR T. Albrecht	24b. REGISTRAR'S SIGNATURE T. Albrecht	
VS A15ME 5M 2 57					JUN 11 '58		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06779

6780

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 127 High St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenburn Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First John	Middle Hamilton	Last Cosby Jr.	4. DATE OF DEATH June 7, 1958	Month June	Day 7	Year 1958	
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/87	9. AGE (in years 70 from last birthday) yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY City Construction		11. BIRTHPLACE (State or foreign country) Milton N.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John H. Cosby Sr.				14. MOTHER'S MAIDEN NAME Mary Wilson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John H. Cosby Jr.		Address 127 High St., Cambridge Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure & emphysema</i> INTERVAL BETWEEN DUE TO <i>1 mo.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arterio-sclerotic CVD</i> 7 yrs (c) <i>Arterio-sclerotic gen-</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>June 7, 1958</u> that I last saw the deceased alive on <u>June 7, 1958</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>WT Thompson</u> M.D. <u>Cambridge, Md. June 9, 1958</u> DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. RECD BY REGISTRAR DATE JUN 10 1958		24b. REGISTRAR'S SIGNATURE <u>Alfred E. Egan</u>			
VS AIS (4) 15M 9/55									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6781

CERTIFICATE OF DEATH

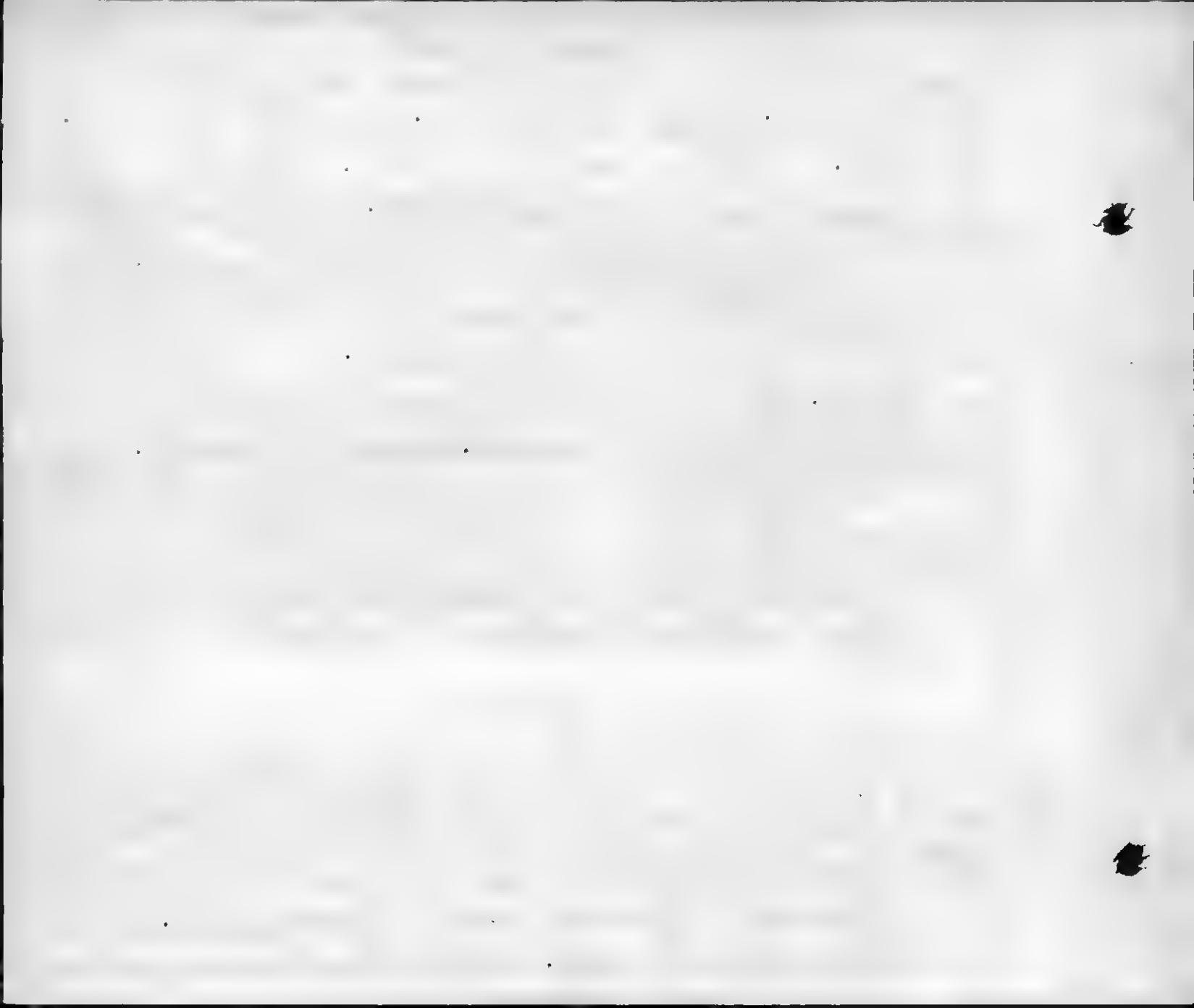
06781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	c. LENGTH OF STAY IN 1b 3 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home		d. STREET ADDRESS Cambridge Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen	First	Middle	Last
		Shepherd	Hicks
4. DATE OF DEATH Month June Day 11 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/15/81
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James S. Shepherd		14. MOTHER'S MAIDEN NAME Elizabeth Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Reg. Henry		Address Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 73X DUE TO Infectious mononucleosis c acute toxemia		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid arthritis, chronic severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1958, 19, to June 17, 1958, that I last saw the deceased alive on June 4, 1958, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED June 16, 1958			
ACTUAL SIGNATURE I.D. Thompson PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/58	
22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge	
23. FUNERAL DIRECTOR'S SIGNATURE L'Compte Funeral Service		ADDRESS Cambridge Md.	
24a. REC'D BY REGISTRAR DATE JUN 19 '58		24b. REGISTRAR'S SIGNATURE D. L. Compte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

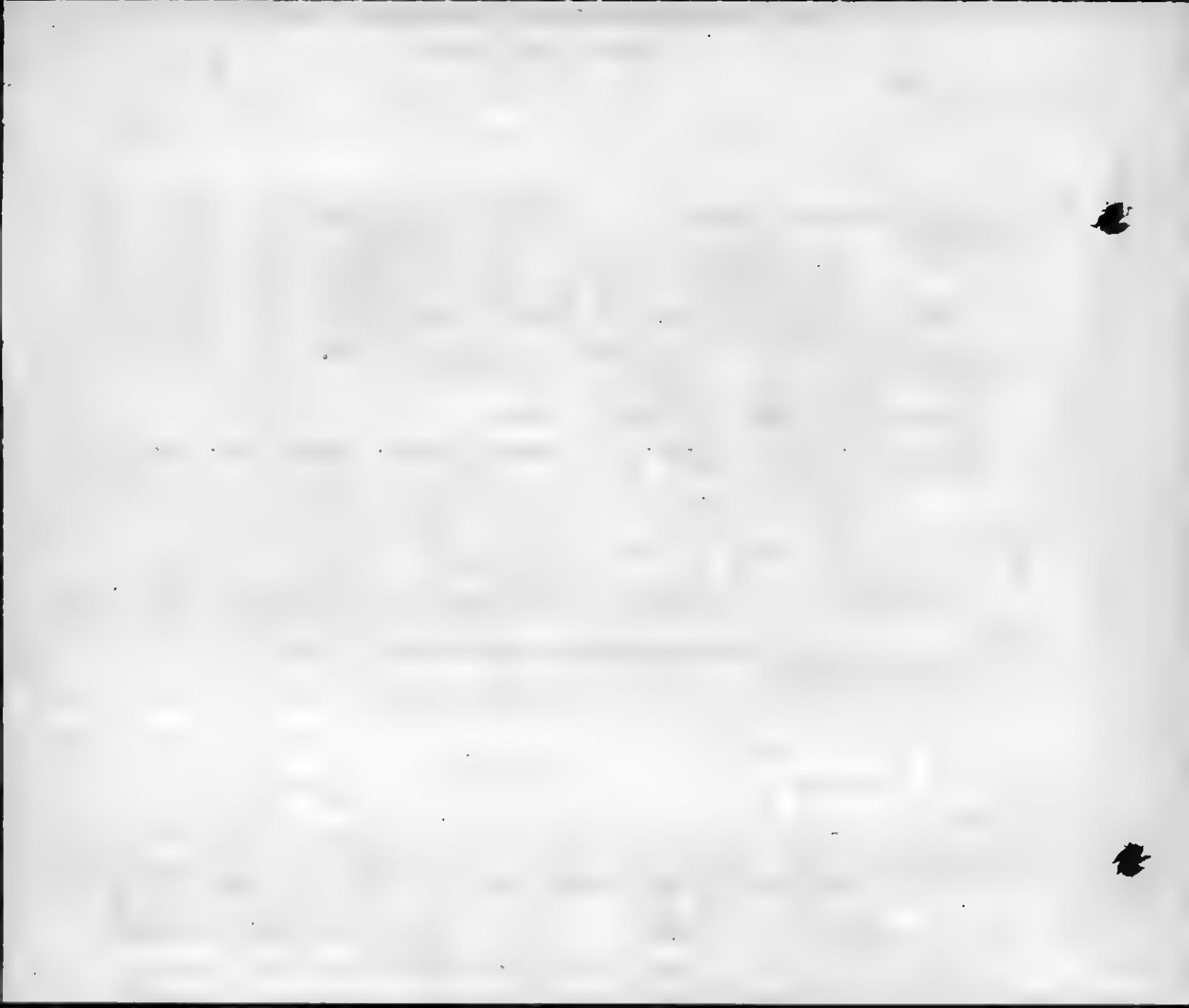


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6782 CERTIFICATE OF DEATH

06781

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Washington Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Elizabeth Bryan		First Elizabeth	Middle Bryan
		Last Hughes	4. DATE OF DEATH June 22 1958
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
13. FATHER'S NAME Daniel Bryan		14. MOTHER'S MAIDEN NAME Mary Chester	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-8301	17. INFORMANT Address Enoch Hughes, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. i.e. i		DUE TO (b) Cardiac Decompensation 2 DAYS	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14, 1958 , to June 22, 1958 , that I last saw the deceased alive on June 20, 1958 , and that death occurred at 11:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Alfred R Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md. DATE SIGNED 6/23/58	
22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/1958	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Alfred R Maryanov		22d. LOCATION (City, town, or county) Cambridge, Maryland	(State)
		24a. REC'D BY REGISTRAR DATE JUL 8 '58	24b. REGISTRAR'S SIGNATURE Alfred R. Maryanov
VS A15 (4) 1SM 9/53			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6783

CERTIFICATE OF DEATH

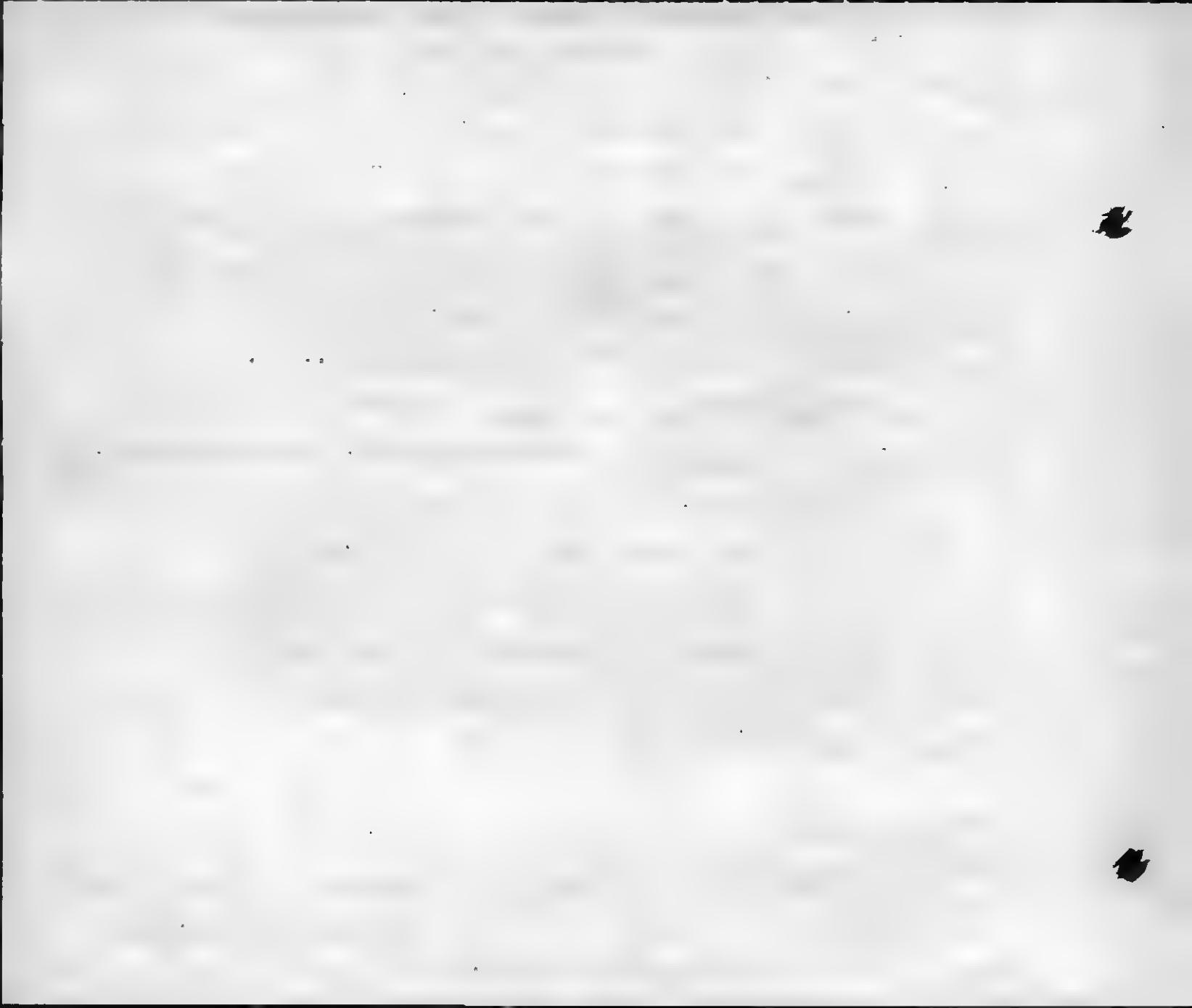
06782

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Cambridge		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		d. STREET ADDRESS RFD 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Emily	Last Jackson	4. DATE OF DEATH	Month June	Day 29	Year 1958
5. SEX	6. COLOR OR RACE Female Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 20, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Graham			14. MOTHER'S MAIDEN NAME Emma Jane Boardley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Jackson, RFD 2, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Cerebral haemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arterio-sclerotic CVD (c) Arterio-sclerosis, gen INTERVAL BETWEEN ONSET AND DEATH 10 days							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emaciation, No get fatigued							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1958 , to June 29, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at Cambridge, Md. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James W. Thompson		ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED July 2, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/1958		22c. NAME OF CEMETERY OR CREMATORIUM Airey Cemetery		22d. LOCATION (City, town, or county) (State) Dorchester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Katherine Hollingshead		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '58		24b. REGISTRAR'S SIGNATURE Albert E. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6784

CERTIFICATE OF DEATH

Reg. Dist. No.

P6783

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge—Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna — Rural	
3. NAME OF DECEASED (Type or print) First Lear Middle Ellen Last Jones		d. STREET ADDRESS R.F.D. #1, Box 116	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1900
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Farrare		14. MOTHER'S MAIDEN NAME Emma Pinkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 219-05-0751 17. INFORMANT Address Charles Jones, Sr., Vienna, Maryland, RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 756.2 DUE TO Acute diffuse peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Meckel's diverticulitis (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at 8:20A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.C.H. Schmidt M.D. ADDRESS (Street, city or town, state) 2195 Washington St. 26 June 58 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 29, 1958 22c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery	
22d. LOCATION (City, town, or county) Vienna, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE JUN 30 '58 24b. REGISTRAR'S SIGNATURE DeLoach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785

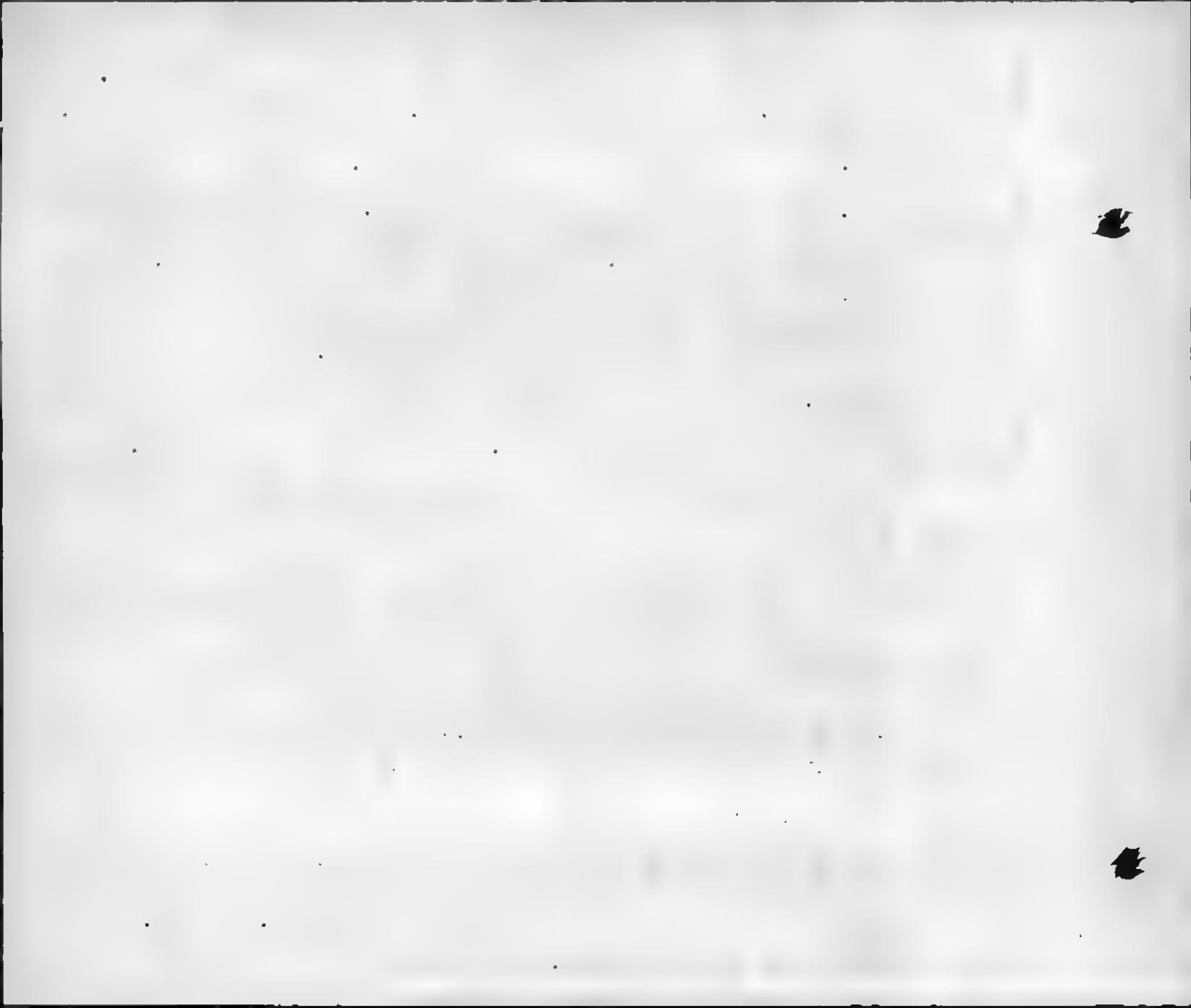
CERTIFICATE OF DEATH

Reg. Dist. No.

06784

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Hill Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS Golden Hill Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Oscar	Middle A.	Last Keene	4. DATE OF DEATH June 1, 1958	Month June	Day 1	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/70	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 87	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Golden Hill Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H. Keene				14. MOTHER'S MAIDEN NAME Eliza Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Louise Tinkham		Address Penscola Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cardiovascular-renal disease INTERVAL BETWEEN ONE AND DEATH 7 MONTHS							
44dx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/27/58 to 1 June 1958 , that I last saw the deceased alive on 1 JUNE 1958 , and that death occurred at 9:50A M, from the causes and on the date stated above. ACTUAL SIGNATURE Walter E. Gunby Jr. ADDRESS (Street, city or town, state) 105 CHURCH ST CAMBRIDGE MD. DATE SIGNED 3 JUNE 58 PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Episcopal Church Cemetery		22d. LOCATION (City, town, or county) Taylors Is. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR JUN 5 '58		24b. REGISTRAR'S SIGNATURE Al. Compte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6786 CERTIFICATE OF DEATH

Reg. Dist. No.

06785

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Dorchester MARYLAND		Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William	Middle Deyer
		Last Keene	4. DATE OF DEATH June
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH May 16, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ice Delivery	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md
13. FATHER'S NAME Draper Keene		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 213-03-6527	17. INFORMANT Lessie Keene, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ to _____; that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) W. H. Hawks		22d. LOCATION (City, town, or county) (State) Meekins Neck, Dor. Co., Md. 6/8/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1958	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Meekins Neck Ceme Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D. BY REGISTRAR JUN 18 1958 DATE	24b. REGISTRAR'S SIGNATURE

الله يحيى

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06786

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE N.J. <u>Harrison</u> b. COUNTY Unknown <u>Bethelton-Bethel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN lb <u>L Day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		d. STREET ADDRESS <u>Gloucester N.J.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ivy Leonard</u>		4. DATE OF DEATH Month June Day 29, Year 1958	
5. SEX Male <u>White</u>		6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12/24/1918</u>		9. AGE (in years from last birthday) 39 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Cambridge Md.</u>		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME <u>Daniel C. Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Emma Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <u>World War II</u> No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-18-1595</u>	
17. INFORMANT <u>Mrs William Harvey</u>		Address <u>Hurlock Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>33IX</u>		CEREBRAL HEMORRHAGE INTERVAL BETWEEN ONSET AND DEATH 20 HRS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Who at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ALFRED R. MARYANOV</u>		ASST. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM ADDRESS <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salem Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
		24b. REGISTRAR'S SIGNATURE <u>Albert LeCompte</u>	

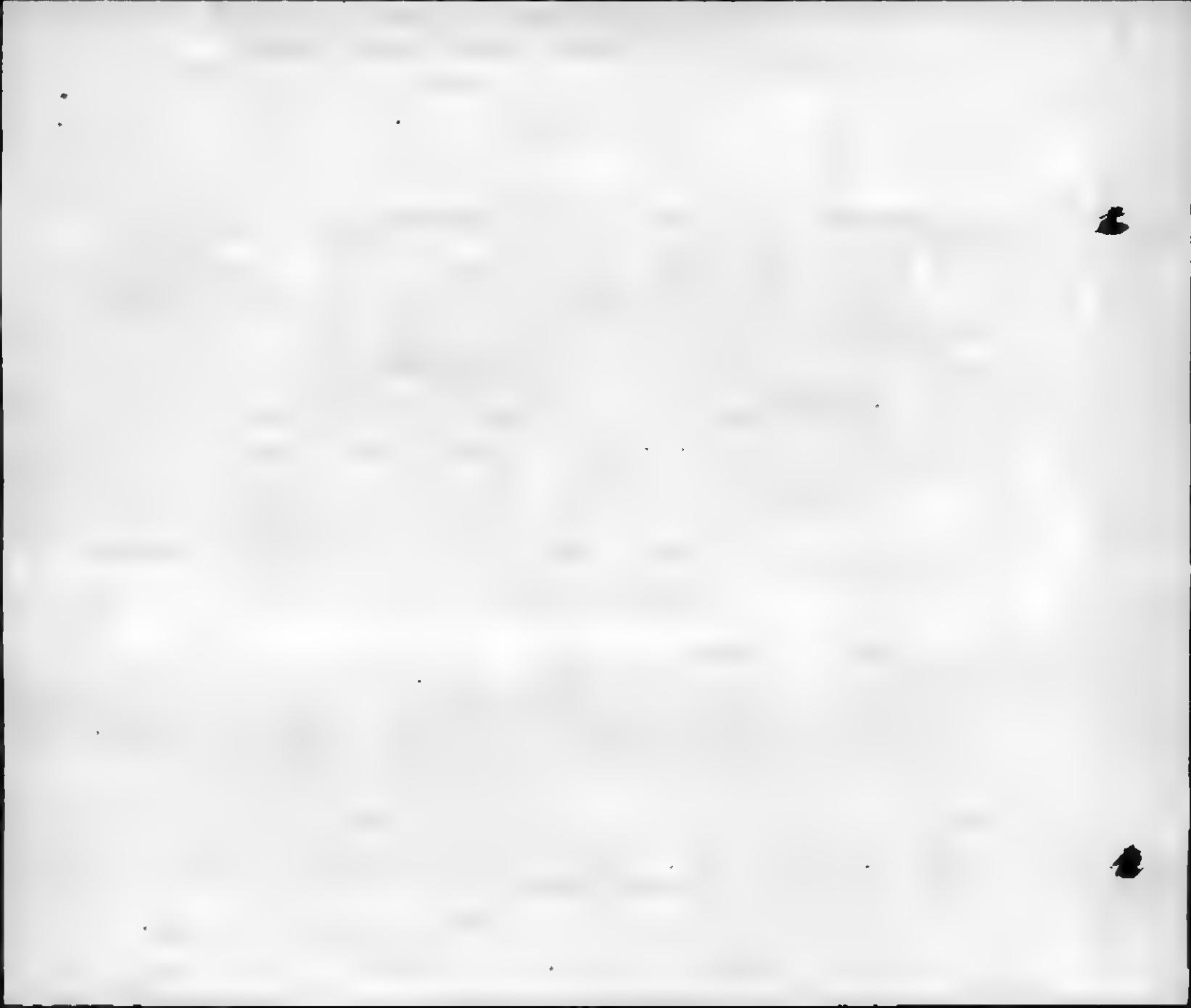


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **Q6787**

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 3		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD # 3		d. STREET ADDRESS Cambridge RFD # 3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge RFD # 3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James		First Middle Last Mc Cready		4. DATE OF DEATH June 13 1958		Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/1903		9. AGE (in years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Cambridge RFD # 3		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James W. Mc Cready			14. MOTHER'S MAIDEN NAME Annie Bowers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-11-1526		17. INFORMANT Mrs James Mc Cready		Address Cambridge RFD # 3		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH Instart								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted with 12 ga. Winchester shot gun.						
20c. TIME OF INJURY Hour a. m. p. m. 6/13 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge, Dor. Co.	(County) 1.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Face Jr.</i>		DATE SIGNED 6/16/58						
EXAMINER'S NAME (Type) Dr. John Face Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/58		22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR JUN 19 '58		24b. REGISTRAR'S SIGNATURE <i>Albert LeCompte</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06789

Reg. Dist. No.

6788

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 121 A Race Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence Henry Mills		First	Middle	Last	4. DATE OF DEATH June 26, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1890	9. AGE (In years from birthday) 68 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sail & Awning Maker retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Joseph K. Mills		14. MOTHER'S MAIDEN NAME Jennie Price						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-8969		17. INFORMANT Mrs. Elizabeth K. Mills, 121 A. Race St., Cambridge		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (b)) Carcinoma of pancreas INTERVAL BETWEEN ONSET AND DEATH Unknown								
DUE TO (b) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck left femur 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed 5 A.M. 6/19/58						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6/19 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Cambridge, Dor.	(County) d.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Ace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Dr. John Ace Jr.		6/26/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shores</i>		ADDRESS 10 Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Old school		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records after burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6789

CERTIFICATE OF DEATH

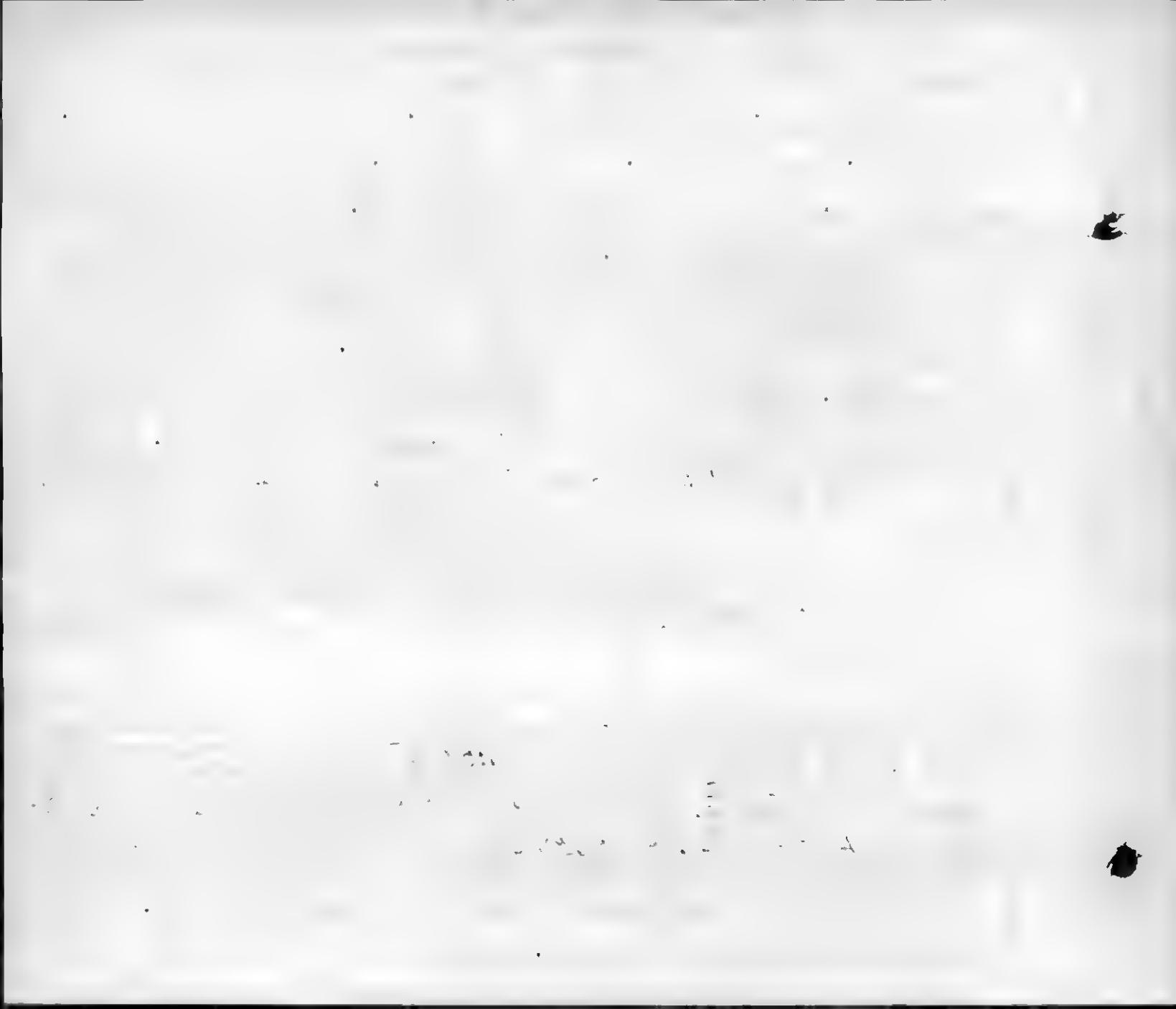
Reg. Dist. No.

06790

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 4 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 506 Oakley St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle W.	Last Mowbray	4. DATE OF DEATH	Month June	Day 30,	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/11/77	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 80	IF UNDER 24 HRS. Days 0	Year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General Labor		11. BIRTHPLACE (State or foreign country) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Mowbray				14. MOTHER'S MAIDEN NAME Annie Pattison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-07-7736		17. INFORMANT Mrs John W. Mowbray		Address Cambridge Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MALIGNANT MELANOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) HYPERTENSION							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3/6/58		20f. (City or town) (County) Cambridge (State) Md.	
21. I certify that I attended the deceased from 3/6/58 to 6/29/58 , that I last saw the deceased alive on 6/29/58 , and that death occurred at 11:50 P.M. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE WALTER E. GUMBY JR.		ADDRESS (Street, city or town, state) CAMBRIDGE DATE SIGNED JULY 58					
PHYSICIAN'S NAME (Type) WALTER E. GUMBY JR.		MATERIAL					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/58		22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR Jul 7 '58		24b. REGISTRAR'S SIGNATURE LeCompte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6790

CERTIFICATE OF DEATH

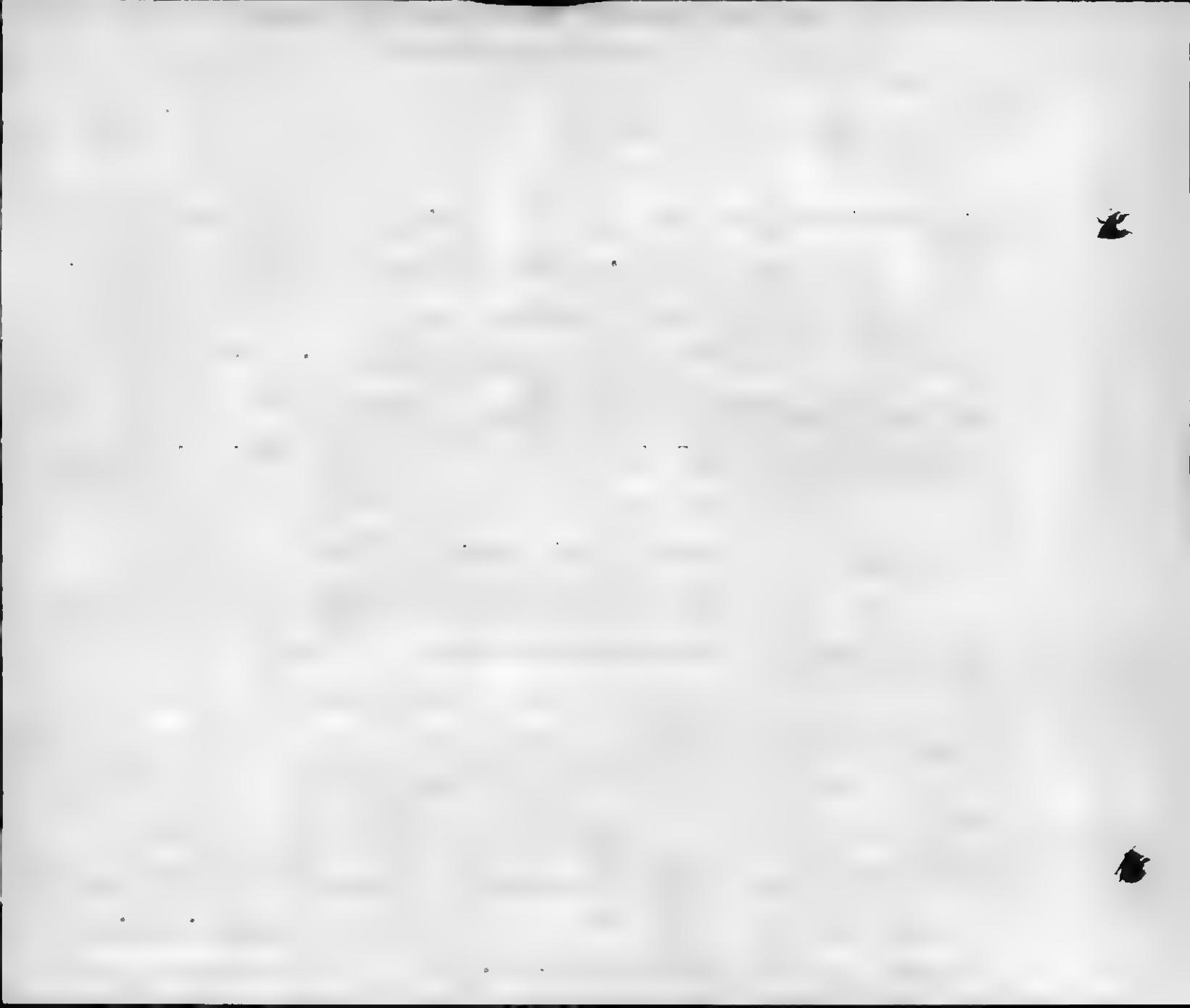
Reg. Dist. No.

06791

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Clair Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) James		First H.	Middle Payne
4. DATE OF DEATH June 13, 1958	Month June	Doy 13	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1891
9. AGE (in years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Howard Payne	
14. MOTHER'S MAIDEN NAME Mary Payne		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-07-7931		17. INFORMANT Paul Pinder, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterio-sclerotic CVD (c) Arterio-sclerosis gen		INTERVAL BETWEEN ONSET AND DEATH 6 mos ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May , 1958, to June 13, 1958 , that I last saw the deceased alive on June 13, 1958 , and that death occurred at 20 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED June 14, 58.	
ACTUAL SIGNATURE H. Thompson	PHYSICIAN'S NAME (Type) Geo	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 6/15/1958		22c. NAME OF CEMETERY OR CREMATORIUM Rock Cemetery	22d. LOCATION (City, town, or county) (State) Dorchester Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert Hollings		24a. REC'D BY REGISTRAR DATE JUN 18 '58	24b. REGISTRAR'S SIGNATURE Web search

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6807

CERTIFICATE OF DEATH

Reg. Dist. No.

06792

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burlock - rural</i>	c. COUNTY <i>Dor</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	e. STREET ADDRESS <i></i>
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Howard James Phillips</i>	First	Middle	Last	4. DATE OF DEATH <i>6/13 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR FACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/8/1878</i>	9. AGE (In years (In months and days) yrs.) <i>80</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. CHIEF OF WHAT COUNTRY? <i>A.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Moving - it, farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>			
13. FATHER'S NAME <i>James Phillips</i>		14. MOTHER'S MAIDEN NAME <i>John Bradley</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>West J. Phillips, Burlock, Md</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Arterial failure gradual</i>	INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
(b) DUE TO <i>Generalized Artherosclerosis</i>	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>General Debility of Age</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <i></i>	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
---	---	--	---	---	--------------------------------	---------------------	--------------------

21. I certify that I attended the deceased from <i>Feb 1, 1958</i> , to <i>6-13, 1958</i> , that I last saw the deceased alive on <i>6-13, 1958</i> , and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W.E. Lennon</i>	M.D.	ADDRESS (Street, city or town, state) <i>Federal Building, Fedalsburg, Md</i>	DATE SIGNED <i>6-10-58</i>				

22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>6/16/58 East New Market</i>	22b. DATE THEREOF <i>6/16/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>East New Market</i>	22d. LOCATION (City, town or county) <i>East New Market Md</i>	(State) <i></i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.E. Lennon, M.D.</i>		ADDRESS <i>6th & Maryland East New Market, Md</i>	24a. REC'D BY REGISTRAR <i>JUN 19 1958</i>	24b. REGISTRAR'S SIGNATURE <i>Q. L. Smith</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

CERTIFICATE OF DEATH

Reg. Dist. No.

06793

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Md.		b. COUNTY		Dorchester Co.	
Dorchester Co.				c. LENGTH OF STAY IN lb RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		25 Years		d. STREET ADDRESS		Cambridge Md.		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		116 Locust St.		116 Locust St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Louise		Taylor		Porter	June	22,	19	58			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.					
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1905	53	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY					
Nurse		Nursing Home		Philadelphia Pa.		USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Michall Wooten Taylor				Sally Wooten							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)											
DUE TO Cronary Thrombosis - Hyper tension Cardio Vascular Disease											
DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus - 5 yrs.											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Jan 4, 1957, to June 22, 1958, that I last saw the deceased alive on June 22, 1958, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE Debra E. Bunker M.D. 300 Maryland Ave. 6-75-58											
DATE SIGNED											
PHYSICIAN'S NAME (Type)		Cambridge - Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Co.		22d. LOCATION (City, town, or county) Cambridge		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS LeCompte Funeral Service		24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE Albert E. Bunker					

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06794**

1		TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it at the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.										TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.	
1. PLACE OF DEATH a. COUNTY		Eastern Shore State Hospital Dorchester, Cambridge MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland b. COUNTY Worcester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Crisfield					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Eastern Shore State Hospital				d. STREET ADDRESS		Box 126A RFD #1					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First Peter		Middle		Last Purcell		4. DATE OF DEATH		Month 6	Day 28	Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1893		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Purcell		14. MOTHER'S MAIDEN NAME Rebecca ?											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 213-18-4730		17. INFORMANT		MEDICAL RECORDS		Address					
								Eastern Shore State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pneumothorax											
527.1		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 day									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		?									
		DUE TO		?									
		(c)		?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
General arteriosclerosis • Chronic brain syndrome A.S.													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient Robert Bates choked this patient											
20c. TIME OF INJURY 4:15 p.m. 6/27/58		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office, etc.) West Ward Toilet		20f. (City or town) Cambridge		(County) Dorchester		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 6/28/58											
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		22b. DATE THEREOF 6-30-1958		22c. NAME OF CEMETERY OR CREMATORIUM SUNNYRIDGE TAVERN		22d. LOCATION (City, town, or county) Crisfield		(State) MD					
23. FUNERAL DIRECTOR'S SIGNATURE Robert H Bradshaw MD		ADDRESS Crisfield		24a. REC'D BY REGISTRAR Date 1958		24b. REGISTRAR'S SIGNATURE O. Leach							

1

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6792

CERTIFICATE OF DEATH

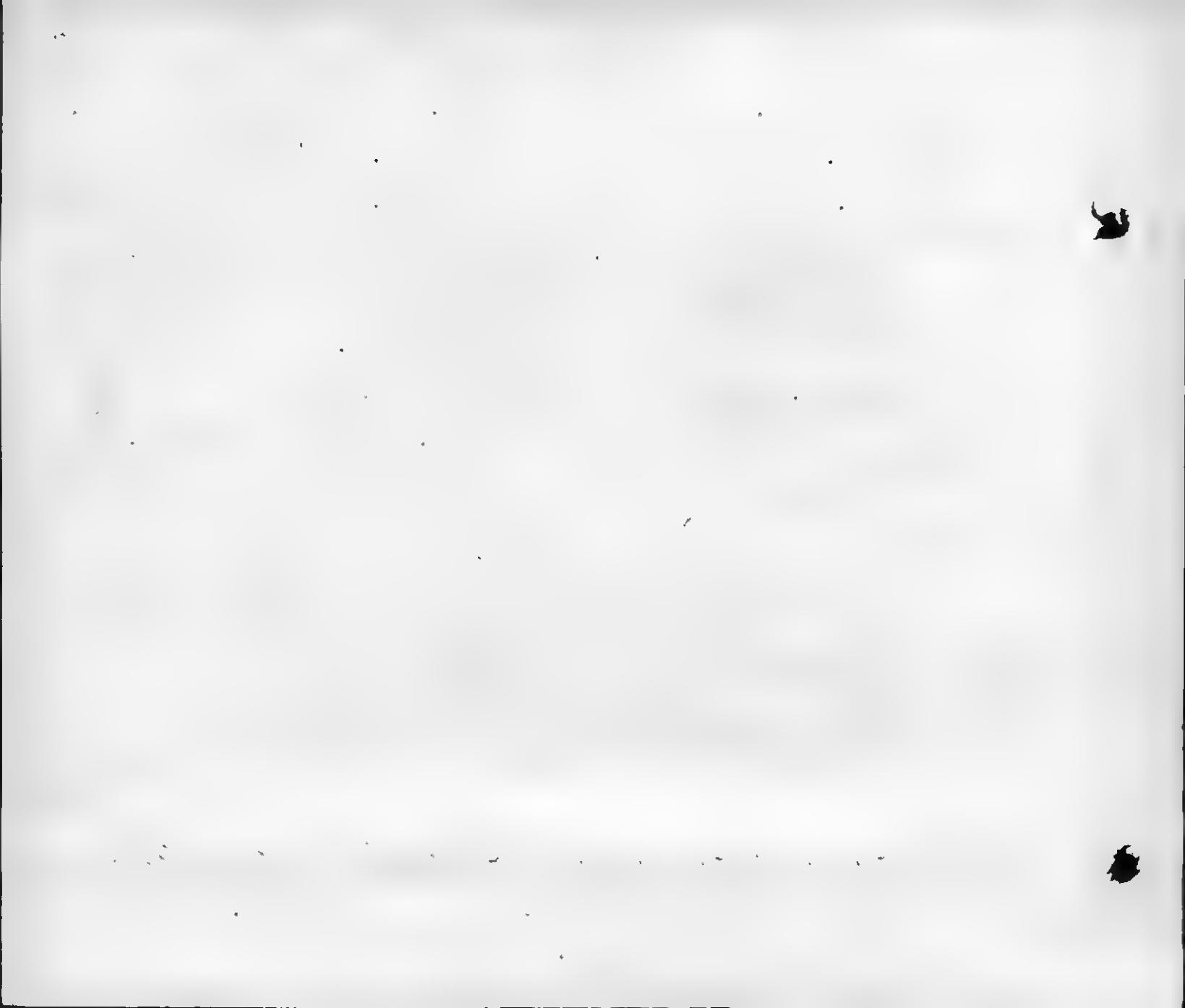
Reg. Dist. No.

06795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and may be used within 72 hours after death.

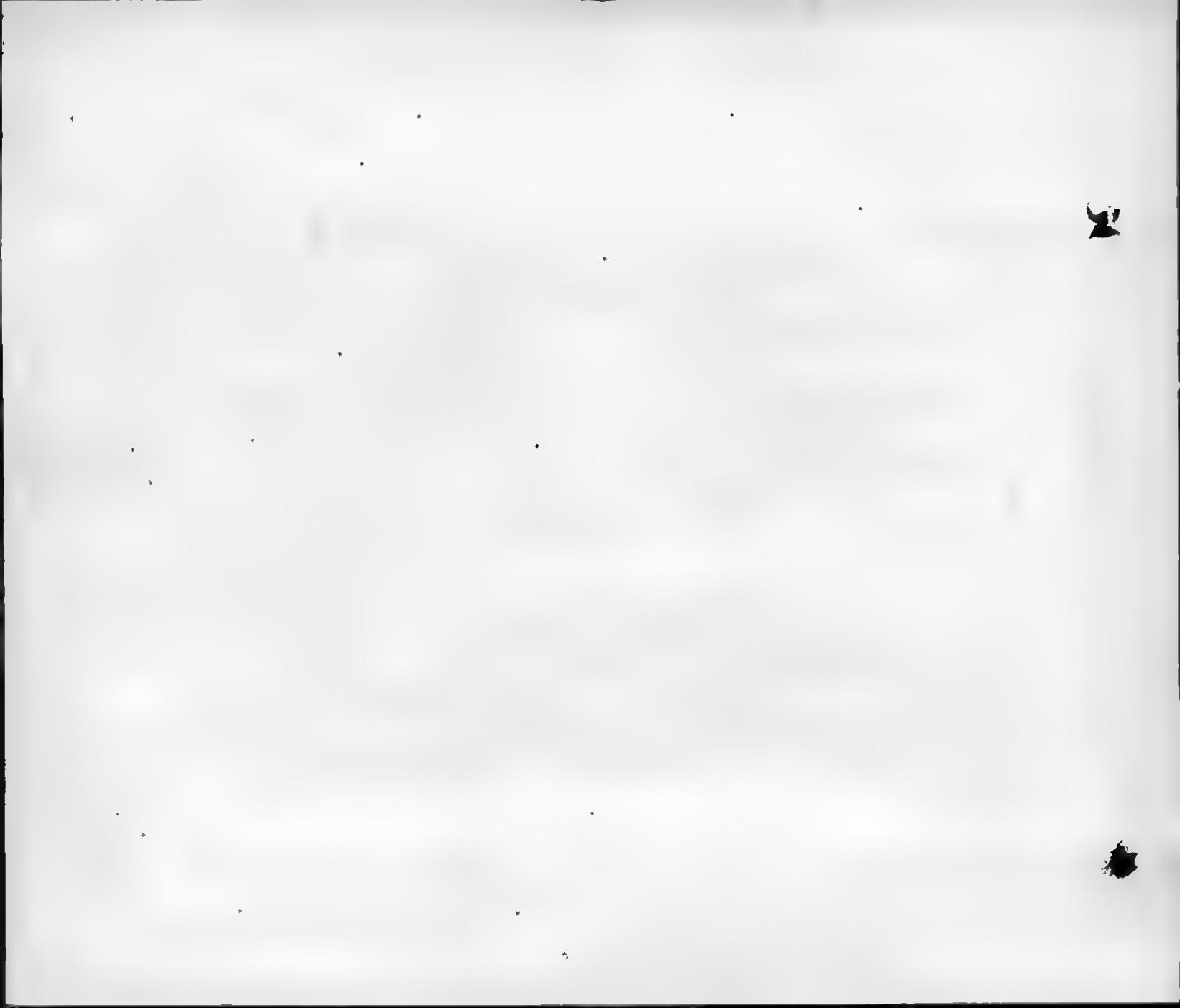
1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS / Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles		First I.	Middle . Robinson	4. DATE OF DEATH June 29, 1958	Month June	Day 29	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/28/58	9. AGE (In years lost birthday) yrs. 20	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 20	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles G. Robinson		14. MOTHER'S MAIDEN NAME Betty R. Shores					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles G. Robinson		Address Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first DUE TO (b) DUE TO (c)		Crushed anaemia atelectasis - Pneumaturity				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-28- , 19 58 , to 6-29- , 19 58 , that I last saw the deceased alive on 6-29-58 , 19 58 , and that death occurred at M.D. , from the causes and on the date stated above. ACTUAL SIGNATURE Albert E. Bunker						ADDRESS (Street, city or town, state) 200 Maryland Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/58		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR JUL 8 '58		24b. REGISTRAR'S SIGNATURE Glenn	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Item No. 6793	CERTIFICATE OF DEATH	Reg. Dist. No. 06796							
1. PLACE OF DEATH a. COUNTY Dorchester Co.					2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.					b. COUNTY Dorchester Co.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.					c. LENGTH OF STAY IN 1b 3 Days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital					d. STREET ADDRESS 110 Church St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Margaret		Middle C.	Last Shepherd	4. DATE OF DEATH June		Month	Day	Year	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8/31/84	9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS Days 13	Hours 00	Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Uniontown Pa.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Edward Cronin					14. MOTHER'S MAIDEN NAME Margaret Lancig										Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. George H. Shepherd		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO HYPER TENSIVE CARDIO - VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I attended the deceased from 1/4 , 19 58 , to 6/5 , 19 58 , that I last saw the deceased alive on 6/5 , 19 58 , and that death occurred at 3:05 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) WALTER E. GUNBY JR 105 CHURCH ST		DATE SIGNED 6/28/58															
ACTUAL SIGNATURE WALTER E. GUNBY JR		M.D.																	
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR CAMBRIDGE MD.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/58		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.		(State)											
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE Alb. Schuck													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-pass permit. Then please remove carbon paper. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6809

CERTIFICATE OF DEATH

Reg. Dist. No.

06797

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN TB Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rhodesdale - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Finchville		d. STREET ADDRESS / Finchville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Elwood		First	Middle	Last	4. DATE OF DEATH Sheppard	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1887	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0	Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Caroline Poultry Farms		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME James S heppard		14. MOTHER'S MAIDEN NAME Lucinda Roberts						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO 220-26-3675		17. INFORMANT Myrtle Welch, 1811 Alabama Ave., S.E., Washington		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia		DUE TO Urinary retention		INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {		(b) Urinary retention		DUE TO Carcinoma of prostate		INTERVAL BETWEEN ONSET AND DEATH 2 years		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 6	Day 17	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Federal Hill Cemetery	20f. (City or town) Federalsburg	(County) Maryland
21. I certify that I attended the deceased from 6-13-1958 , to 6-17-1958 , that I last saw the deceased alive on 6-15-1958 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.		ACTUAL SIGNATURE John C. Rawlins		ADDRESS (Street, city or town, state) 202 High St., Federalsburg, Md.		DATE SIGNED 6-23-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24e. REC'D BY REGISTRAR SUN 25 58		24f. REGISTRAR'S SIGNATURE Aut. leach		

2

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

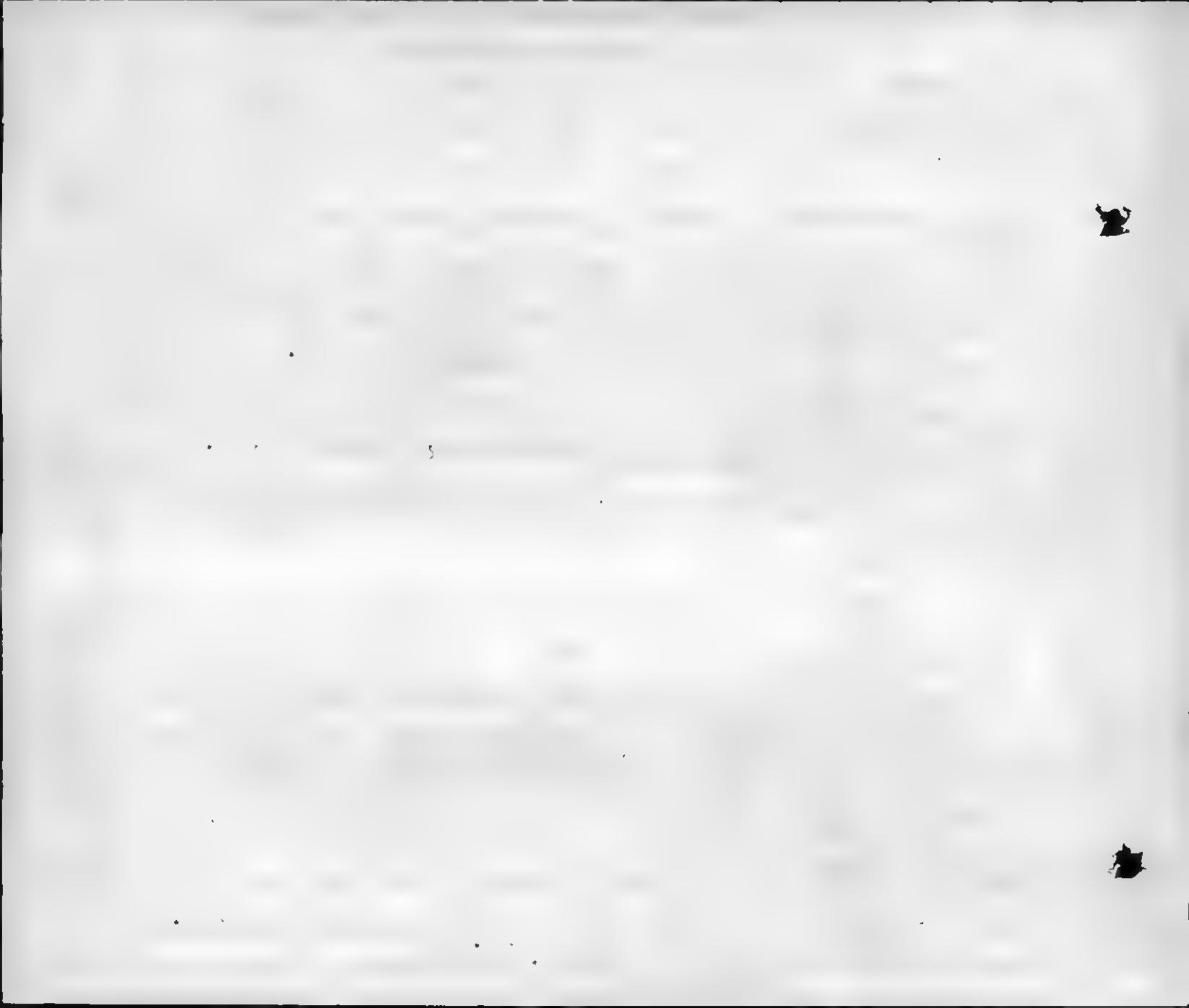
06798

6810

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural Home		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edward		First	Middle	Last	4. DATE OF DEATH 6	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1884		9. AGE (In years less birthday) 74 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Fishing Creek, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Simmons		14. MOTHER'S MAIDEN NAME Emma Aaron						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Leon Tyler, Fishing Creek, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 17BACMIAL Thrombosis of Heart						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Fishing Creek	(County)	(State)
21. I certify that I attended the deceased from April 23, 1958 to June 24, 1958 , that I last saw the deceased alive on June 29, 1958 , and that death occurred at 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fishing Creek, Md.								
ACTUAL SIGNATURE Maurice I. Shab			M.D.		DATE SIGNED 6/29/58			
PHYSICIAN'S NAME (Type) Maurice I. Shab								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/30/58	22c. NAME OF CEMETERY OR CREMATORIUM Hoosier Memorial Church		22d. LOCATION (City, town, or county) Fishing Creek, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, 118 High St.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR JUL 2 '58	24b. REGISTRAR'S SIGNATURE Almenach			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6794

CERTIFICATE OF DEATH

06799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 440 High Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Annie	Middle Warren	Last Slacum
4. DATE OF DEATH	Month June	Day 8,	Year 1958
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Oglethorpe, Ga.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ella Lassiter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 266-18-0411	17. INFORMANT Address Johnnie Ponder, Cambridge, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma right lung			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)			
DUE TO DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-25-49 , 19_____, to 6-8-58 , 19_____, that I last saw the deceased alive on 6-5-58 , 19_____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue		DATE SIGNED 6/13/1958	
ACTUAL SIGNATURE <i>Albert E. Bunker, M. D.</i>			
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.		Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/1958	22c. NAME OF CEMETERY OR CREMATORIUM East New Market Ceme.	22d. LOCATION (City, town, or county) (State) East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hubert W. St. George</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JUN 16 '58
			24b. REGISTRAR'S SIGNATURE <i>Deborah Smith</i>

عمر سلطان

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6795 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)									
o CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb		a. STATE Ind.									
Cambridge		1 week		b. COUNTY Dorz									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Cambridge, Maryland				East New Market									
3. NAME OF DECEASED (Type or print)		First Middle		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
Fred		August Suhr		Month Day Year									
5 SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8/1887		9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
Mowing													
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
F. A. Suhr		M. Fred & July East New Market											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
(If yes, give war or dates of service)								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 week			
442 X		DUE TO		Hypertension				(b)		2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last:		DUE TO		Hypertensive Cardiovascular Disease				(c)		1 yr			
Nephritis Chronic													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I attended the deceased from June 18, 1958, to June 21, 1958, that I last saw the deceased alive on June 21, 1958, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Bannister M.D. DATE SIGNED 6-29-58													
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF 6/29/58		22c. NAME OF CEMETERY OR CREMATORIAL East New Market		22d. LOCATION (City, town, or County) East New Market		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR JUN 27 '58		24b. REGISTRAR'S SIGNATURE A. L. French							
John J. McLaughlin, East New Market, Md.													



MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

6796

CERTIFICATE OF DEATH

06801

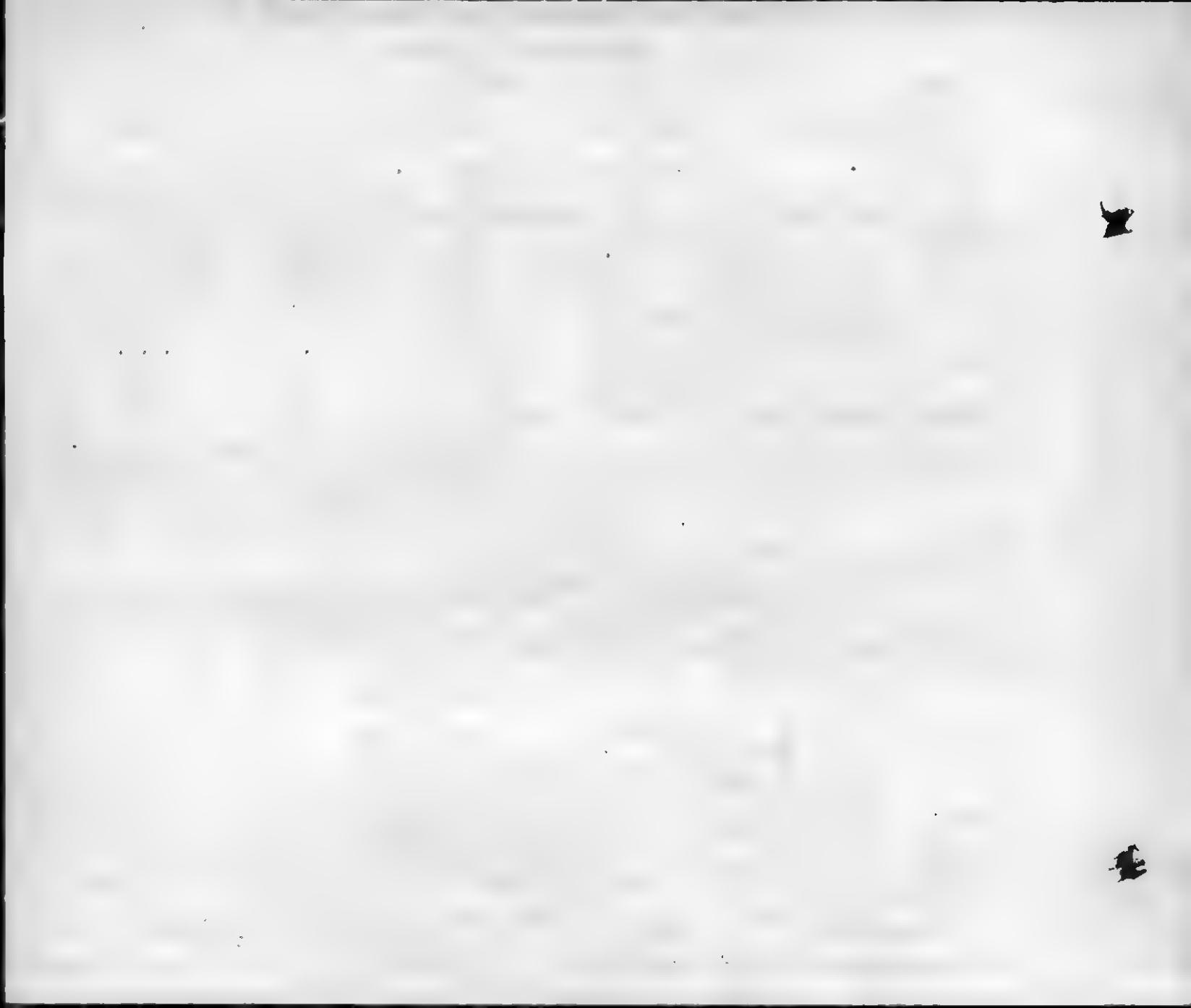
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 239 Goldsborough Ave		e. STREET ADDRESS 239 Goldsborough Ave		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah		First Sarah	Middle M.	Last Travers	4. DATE OF DEATH Month 6 Month 11 Day 1958	Day	Year
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> 3/10/1879	9. AGE (In years last birthday) 79 yrs	10. IF UNDER 1 YEAR Months 3 Days 10	11. IF UNDER 24 HRS. Hours 10	12. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Fishing Greek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Meekins		14. MOTHER'S MAIDEN NAME Nancy Meekins		Address Cambridge, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ralph Foxwell			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage.						INTERVAL BETWEEN ONSET AND DEATH hours	
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis		(b) DUE TO Hypertension					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple decubitus ulcers Back & heels						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 104 Locust St		20f. (City or town) Cambridge, Md.	(County) Caroline Co. (State) Md.
21. I certify that I attended the deceased from 7/16 , 19 58 , to 8/11 , 19 58 , that I last saw the deceased alive on 6/11 , 19 58 , and that death occurred at 8 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE M. J. Hawks M.D.						ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 6/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/11/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE NAME (Type) Le Compte Funeral Service Cambridge, Md,		24a. REC'D BY REGISTRAR DATE JUN 23 '58		24b. REGISTRAR'S SIGNATURE Albert E. Lewis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55



TO HOSPITAL OR ATTEN IN PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Reg. 4**
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Reg. 2** should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06802**

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Dor.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellisville</i>	c. LENGTH OF STAY IN b. <i>All life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellisville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Corrie Velina Waller</i>		4. DATE OF DEATH <i>8/23/58</i>	
5. SEX <i>Female</i>	6. COLOR OF HAIR <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8/25/1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Quondome</i>	11. BIRTH PLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Cornelius Gray</i>		14. MOTHER'S MAIDEN NAME <i>Susan Gray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Mrs. Thomas Gray, Ellisville</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Toxic myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerosis causing heart failure</i> (c) <i>2nd stage hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mental deterioration due to arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <i>19</i> <input type="checkbox"/> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ellisville</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>7/10</i> , 19 <i>58</i> , to <i>7/23</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/23</i> , 19 <i>58</i> , and that death occurred at <i>Ellisville</i> , M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Hanks</i>		ADDRESS (Street, city or town, state) <i>1234 Main Street, Baltimore, Maryland</i> DATE SIGNED <i>7/23/58</i>	
22a. FUNERAL CREMATION REMOVAL (Check)		22b. DATE THEREOF <i>8/23/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Ellisville</i>
22d. LOCATION (City, town or county) <i>Ellisville</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jules J. Elloughby</i>		24a. ADDRESS <i>East New Market, Md.</i>	24b. REC'D BY REGISTRAR <i>As. Secy.</i>
		24c. DATE <i>JUN 30 '58</i>	24d. REGISTRAR'S SIGNATURE <i>As. Secy.</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

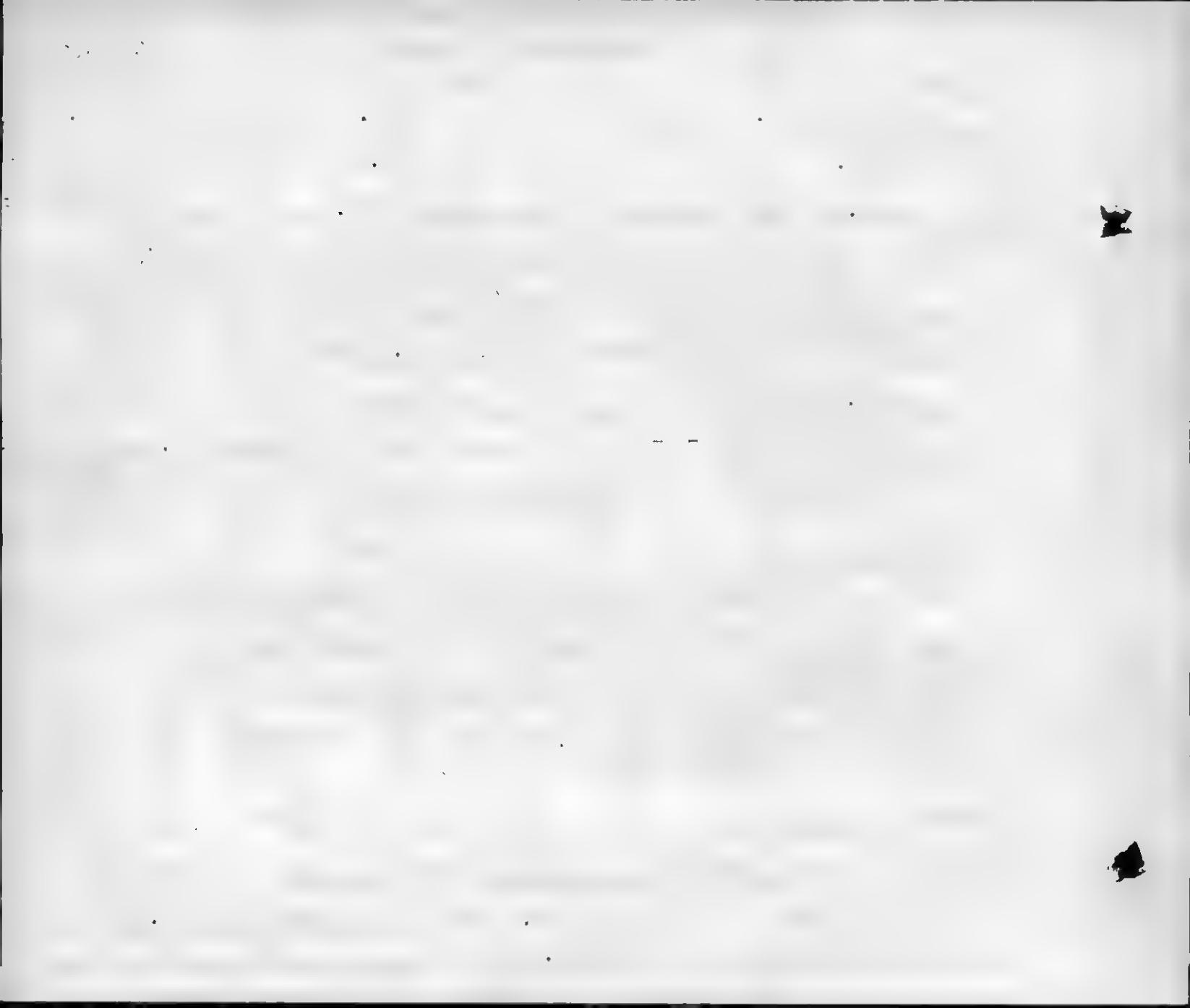
CERTIFICATE OF DEATH

06803

Reg. Dist. No.

6797

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS 203 Maryland Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital				e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Linda Ozman		First	Middle	Last	4. DATE OF DEATH June 5, 1958	Month	Day	Year
5. SEX Male F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/8/98	C. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory		11. BIRTHPLACE (State or foreign country) Talbot Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James A. Ozman			14. MOTHER'S MAIDEN NAME Clara Kemp					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-1244		17. INFORMANT Mrs Harry Dawson		Address 205 Rambler Rd. Cambridge, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Carcinoma</i> (c) <i>Carcinoma Virginia</i>								
INTERVAL BETWEEN ONSET AND DEATH 6 mos								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 11, 1958 , to June 5, 1958 , that I last saw the deceased alive on 6-5-58 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 6-6-58								
ACTUAL SIGNATURE T. W. Barron M.D.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/58		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR JUN 10 '58		24b. REGISTRAR'S SIGNATURE LeCompte	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6798

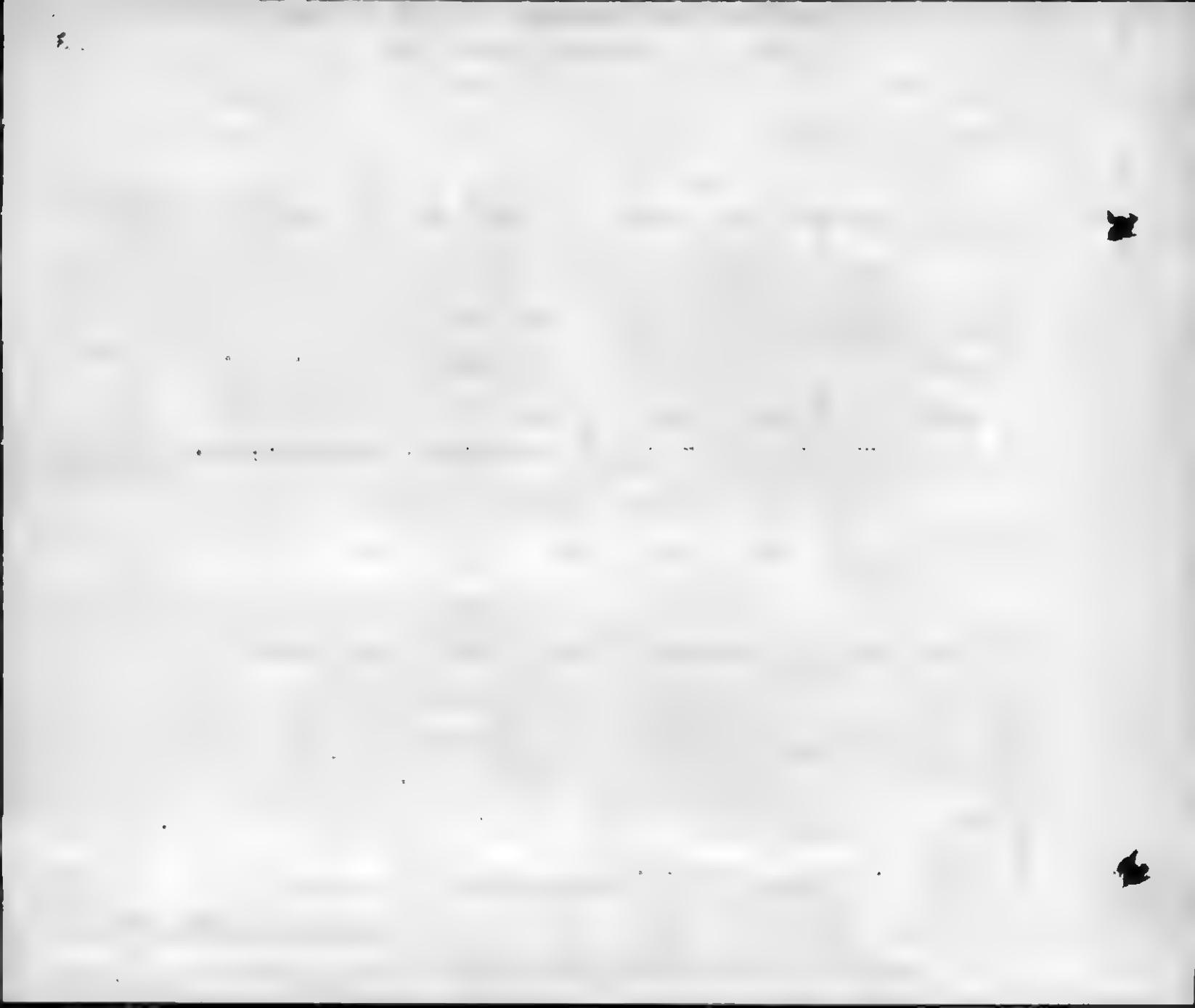
CERTIFICATE OF DEATH

Reg. Dist. No. 06814

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 420 Pine Street		d. STREET ADDRESS 420 Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emerson		First Henry	Middle Ward	Last Ward	4. DATE OF DEATH June 8	Month June	Day 8	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 8, 1900	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. CITIZEN OF WHAT COUNTRY? Address USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hauling		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.				
13. FATHER'S NAME Henry Ward		14. MOTHER'S MAIDEN NAME Sudie Bailey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-8002		17. INFORMANT Agnes Ward, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus				INTERVAL BETWEEN ONSET AND DEATH				
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO						
{ DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from November 1, 1957, to June 8, 1958, that I last saw the deceased alive on June 8, 1958, and that death occurred at 8 A. M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Sudie Bailey</i>				ADDRESS (Street, city or town, state) M.D. 227 Pine St-Cambridge, Md. 6-11-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/1958		22c. NAME OF CEMETERY OR CREMATORIUM Cordtown Cemetery				
22d. LOCATION (City, town, or county) Cordtown, Maryland								
23. FUNERAL DIRECTOR'S SIGNATURE <i>Roger W. Hall</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '58				
				24b. REGISTRAR'S SIGNATURE <i>A. L. Smith</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
SM 2/57



20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6812 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

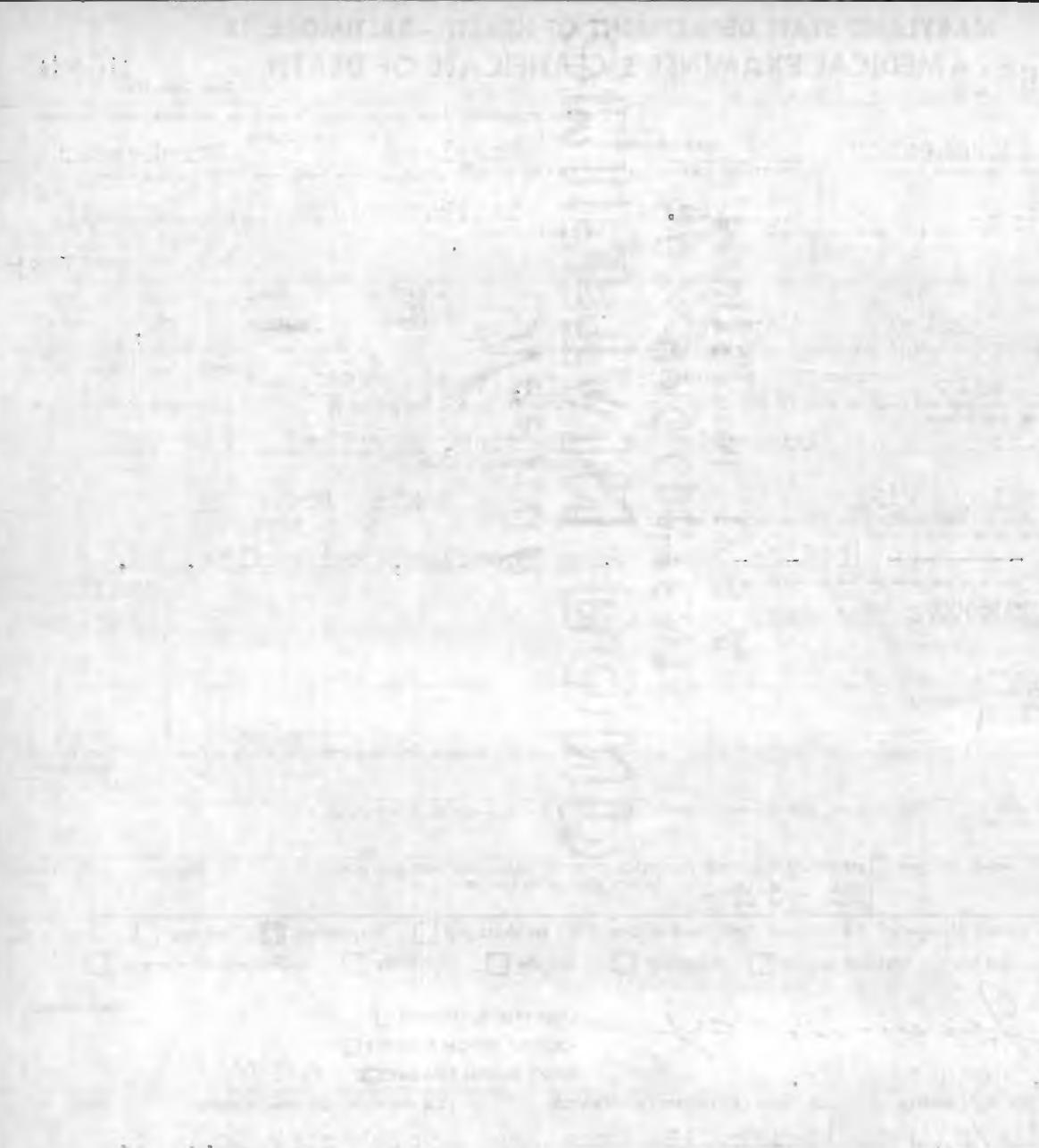
Item 9 Fil-G231 7-14-58 et

Reg. Dist. No.

06805

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithville (Taylors Island)		c. LENGTH OF STAY IN lb 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithville (Taylors Island)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Island)		STREET ADDRESS							
3. NAME OF DECEASED (Type or print) Mabel		First	Middle Vernetta	Last Wheatley	4. DATE OF DEATH June 24, 1958	Month June	Day 24	Year 1958	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1899	9. AGE (in years last birthday) 59 1/2 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Chester, Maryland					
13. FATHER'S NAME Westley Hill		14. MOTHER'S MAIDEN NAME Annie Brown		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-7786		17. INFORMANT John Wheatley, Smithville, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH Instant			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)		DUE TO							
(c)		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/25/58					
EXAMINER'S NAME (Type) Dr. John Mace Jr.									
220. BURIAL, CREMATION, REMOVAL (Specify) Burial		226. DATE THEREOF 6/29/1958		22c. NAME OF CEMETERY OR CREMATORIUM Smithville Cemetery		22d. LOCATION (City, town, or county) Dorchester Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. S. Clark Jr.</i>		ADDRESS Cambridge, Md.		24c. REC'D BY REGISTRAR JUL 8 '58		24b. REGISTRAR'S SIGNATURE <i>Albert E. ...</i>			

DATA
SHEET



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06806

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Few Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Washington	Last Young
4. DATE OF DEATH	Month June	Day 8,	Year 1958
5. SEX Male	6. COLOR OR RACE Neg ro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1905
9. AGE (In years lost birthday) 52 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Seafood Pkg.	12. BIRTHPLACE (State or foreign country) Dorchester Co., Md.
13. FATHER'S NAME George Young	14. MOTHER'S MAIDEN NAME Sarah Mc Cready	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 222-03-9472	17. INFORMANT Marie Johnson, Cambridge, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease with enlarged heart DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pleural effusion right lung - 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 8, 1958 , to June 8, 1958 , that I last saw the deceased alive on June 5, 1958 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue			
ACTUAL SIGNATURE <i>Albert E. Bunker</i>	DATE SIGNED 6-8-58		
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		
22b. DATE THEREOF 6/12/1945	22c. NAME OF CEMETERY OR CREMATORIUM Crapo Cemetery		22d. LOCATION (City, town, or county) (State) Crapo, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hugh M. DeGraff</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE JUN 12 '58	24b. REGISTRAR'S SIGNATURE <i>John L. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VS A15 (4)
 15M 9/55

2023年1月1日-2023年3月31日，新規登録ユーザーがお試し登録する場合

— Samuel M. Dugay